CROWSON

v

LAROWE

DR. JUDD LAROWE

June 06, 2018

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IN THE UNITED STATES DISTRICT COURT

CENTRAL DIVISION

MARTIN CROWSON,

Plaintiff,

vs.

JUDD LAROWE, BRET LYMAN, et al.,

Defendant.

Case No. 2:15-CV-880-RJS

Judge Tena Campbell

DEPOSITION OF DR. JUDD LAROWE

Taken at the Courtyard Marriott
185 South 1470 East
St. George, Utah

On Wednesday, June 6, 2018
At 9:03 A.M.

Reported by: J. Elizabeth Robison, RPR, CCR

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ALSO PRESENT:
James Kenner

EXAMINATION INDEX

P R O C E E D I N G S

* * *

DR. JUDD LAROWE,

having been first duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows:

-oOo-

EXAMINATION

BY MR. SCHRIEVER:

Q. Dr. LaRowe, my name is Ryan Schriever. I represent an inmate by the name of Martin Crowson. Do you know Mr. Crowson?

A. I do not.

Q. Okay. We are here to take your deposition today.

Have you ever had a deposition taken before?

A. Once, a number of years ago. I'm not even sure when.

Q. Okay. What did that case involve?

A. I was asked to be an expert witness in a case where a patient had been on Coumadin and things went awry.

Q. Okay.

A. So...

Q. All right. And that was a number of years ago?

A. It was. Probably at least a decade.

Q. Okay. Well, by way of refresher, then -- and I know you've had a chance to talk to Mr. McGarry, who is an excellent attorney -- but the deposition is our chance to just find out what you would be able to testify to if we were to get to trial. So you're under oath. It's the same as being in trial, except there's no judge here. There's no jury, and we're given a little bit more, latitude to just find out things about the case.

So I'm going to ask you things about your background, qualifications, what you do with the Department of Corrections, what your practice is, and then any knowledge or memory you have of the specific events related to this case.

Does that make sense?

A. Yes, it does.

Q. Okay. You're answering audibly, which is exactly what we need you to do, because we are making a transcript of the deposition. And a lot of times in conversation we have speech patterns that make it really casual, like saying "uh-huh" or "huh-uh." And that requires our court reporter to

make -- to interpret what you're saying. So if you don't say "yes" or "no" to a yes-or-no question, I might remind you just to say "yes" or "no."

A. That would be fine.

Q. Okay.

A. Thank you.

Q. All right. We also -- I don't anticipate that we'll be too long. But if you want to take a break at any point, we can do that.

A. Thank you.

Q. And if I ask you a question that you don't know the answer to or you don't remember, you can tell me that you don't know or you don't remember. That -- those are fine answers. I may probe around the edges to see if we can jog your memory. But I -- we need to know what your knowledge is, what your firsthand knowledge is.

Does that make sense?

A. Yes, it does.

Q. Thank you.

Well, to get started, would you please state your name for the record?

A. My name is Judd LaRowe.

Q. Okay. And LaRowe is spelled -- how do you spell LaRowe?

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A. L-a capital R-o-w-e.
Q. All right. Judd has two Ds; is that right?
A. It does. J-u-d-d.
Q. Where do you practice?
A. At 1664 South Dixie Drive, Suite D-102 in St. George, Utah.
Q. Okay. How long have you been there?
A. Ten years at this location.
Q. What kind of practice do you have there at that location?
A. I have a standard internal medicine practice. So we deal with heart disease, diabetes, basically whatever walks in the door that happens to someone over the age of 17.
Q. Okay. Before we get too far down that road -- I want to come back to that, but what is your educational background and training?
A. I went to the University of Minnesota in Minneapolis for medical school for four years. I did a one-year transitional internship in Grand Rapids, Michigan. After that, I spent three years as a general medical officer in the United States Navy. I was stationed with the Marie Corps for the entirety of my tour, which was three years. I

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spent nine months in Desert Shield and Desert Storm.
After that, I did a full internal medicine residency at the University of Washington in Spokane, so that was three years. At that point, I took a job in Elko, Nevada. I worked for the Elko General Hospital. And at the completion of that term, I actually went out in a partnership in Elko for several more years. I believe it was four more years.
And then I was hired by the University of Utah, Department of Cardiology. They had an extension clinic here in St. George. So I moved here. I joined Dr. Alan Skolnick and practiced there for two years. They then sold the practice to IHC, and I wasn't interested in working for IHC at the time.
So at that point, I went out on my own. That was 2001. Actually, by the time I went out on my own, it was 2002. So that January. And I have been a private practitioner since that point in time. For a brief period, I had another clinic in Mesquite; Mesquite, Nevada. That was for three years. After that, I just solely practiced in St. George, Utah.

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Q. Okay. As far as specific issues that you deal with on a regular basis -- since I don't necessarily know what all falls under the umbrella of "internal medicine," it sounds pretty broad -- I'm just going to ask you specific areas in common practice. And this is in your private practice I'm referring to. We'll talk about your involvement with the Department of Corrections in a minute.
As far as your private practice goes, do you deal with things like alcohol and drug withdrawal?
A. Not very often in my private practice.
Q. Okay. How about head trauma or brain injuries?
A. I certainly do.
Q. Okay.
A. Yes.
Q. And you're familiar with the signs and symptoms of brain injuries?
A. I am familiar with the signs and symptoms of brain injuries.
Q. In this case particular, we're talking about encephalopathy.
Is that a condition that you're familiar with and treat?

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A. It is a condition I'm familiar with.
Q. Is that something you treat in your practice?
A. I don't have that many patients that have encephalopathy. Just due to our population in general in southern Utah, there aren't that many individuals that have it, so the pool is fairly small to draw from.
Q. Okay. You know, just before we got done, I think I should have asked you that, in preparing for the deposition, what records have you reviewed?
A. I have reviewed the records from DRMC and the records from Washington County.
Q. Okay. Does that include the log notes of the -- like, the nurse's notes of --
A. It does include those notes.
Q. Okay. All right. In your involvement with the prison, when did you become involved with the -- with Purgatory jail?
A. I don't actually remember the exact date. I believe it was 2002, but I'm not positive on the actual start date.
Q. And your job there is medical director; is that correct?
A. I am a -- I'm a private consultant or a

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private contractor. I provide medical care for the inmates in coordination with the medical department at Purgatory. So I'm not actually the medical director. I believe that title falls to Jon Worlton.

Q. All right. And is it -- okay. Private contractor. Let's just talk briefly about what the terms of your arrangement with the jail are. Are you on a flat fee, or do they pay you by hour, or how does it work?

A. It's a flat fee.

Q. Do they pay you monthly for that?

A. They do.

Q. Is that the same regardless of the amount of time you put in working there?

A. Yes, it is.

Q. As a private contractor, do you have access to their record-keeping systems?

A. Only when I'm on site.

Q. No remote access, then?

A. There is not.

Q. Do -- how does the -- how do the employees at the jail communicate with you?

A. Several methods. Either via phone or text or faxes, and they will either fax my office, call

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my office, or call my cell phone. So I'm available 24/7. And on the rare times when I'm not, I have a nurse practitioner who covers.

Q. Who's that?

A. His name is Ryan Borrowman.

Q. Okay. I've met Mr. Borrowman.

A. I imagine you have.

Q. But I hadn't put two and two together that he was working for you now.

A. He is.

Q. Okay. How long has Mr. Borrowman worked for you?

A. Since August of last year.

Q. All right. When did you first get to know Mr. Borrowman?

A. When he started working at the Purgatory facility.

Q. How long has he been a nurse practitioner?

A. I think three years, but I'm not positive.

Q. As far as a typical week goes, how much time do you spend at the jail? What's your schedule?

A. Time spent at the jail might be an hour, hour and a half. But I am in contact with the jail multiple times every day.

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Q. Okay. In 2014, Mr. Borrowman was working at the jail as a nurse when this happened. Did you have another nurse practitioner or a physician's assistant that helped you at that time?

A. I did. Her name was Amy Benedict.

Q. Does Amy still work for you?

A. She does not.

Q. When did Amy stop working for you?

A. I believe March of last year.

Q. Is she a nurse practitioner --

A. Oh, I'm sorry.

Q. Oh, go ahead.

A. Actually, June of last year.

Q. Is she a nurse practitioner or a physician's assistant?

A. Nurse practitioner.

Q. Do you know where she is now?

A. She is working for the Heart of Dixie, a cardiology group in town.

Q. Do you know if Amy had any involvement with Mr. Crowson's case?

A. None whatsoever.

Q. Outside of the jail's record-keeping system, do you keep any records on inmates?

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A. I do not.

Q. Do you keep any log of phone calls that you receive?

A. I do not.

Q. If you receive a fax from someone at the jail, is that kept anywhere?

A. If I receive a fax from the jail, I respond to the fax and send it back to them, so that that would be where the record would stay. I don't keep any independent files.

Q. All right. So you, personally, do not have any files related to Mr. Crowson at all?

A. I do not.

Q. Okay. Do you have any independent memory of these events at all?

A. I do.

Q. What do you remember?

A. The best that I can recall, I remember getting a phone call from Mike Johnson. And what he relayed to me was that a patient was having some difficulties, as far as confusion, and the vital signs were not very revealing. They were pretty reasonable at the time. And I remember -- what I remember independently is that we ordered some blood work, a chest x-ray. I just wanted to get a

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better feel for what was going on, because his case was not clear-cut. And we moved him, at that point, into booking for closer observation.

And then I also remember a call from Ryan Borrowman, and at that time, the vital signs had changed. They had gone outside of the normal range. I believe most specifically the pulse rate had risen. And at that point, you know, I elected to have him transported to the emergency room.

Those are my only recollections of the plaintiff. I actually don't recall any interactions prior to that or after that. I'm not even sure I saw him in sick call, so I just don't recall.

Q. Okay. Do you remember, with Mike Johnson, was it one phone call or --

A. I only recall one phone call on that.

Q. Okay. As far as evaluating patients, it's true you rely on nurses there in large part when you're not there; right?

A. I do.

Q. In fact, there's no other way to do it, is there?

A. There is not.

Q. They've got to be your eyes and ears?

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A. They are.

Q. Do you perform any training of the nurses there or the staff?

A. I do not.

Q. Do you have any interactions with Jon Worlton about training?

A. I don't recall that I have.

Q. If someone there were to ask you to come provide training to the staff, is that something that you would be able to do?

A. I would.

Q. Have you ever had any communications with Jon Worlton about this particular case?

A. The only communications I've had was that there would be a case.

Q. Did you speak with him at all about his involvement or lack of involvement?

A. I specifically did not.

Q. Okay. How about Ryan Borrowman? Have you spoken with Mr. Borrowman about the case?

A. We have specifically not. In fact, we discussed not discussing the case.

Q. Okay. And the same question with Mike Johnson?

A. We have not discussed the case.

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Q. How often do you have contact with Mr. Johnson?

A. Quite often. Whenever he works a shift, I will get phone calls. So I have contact with the nursing staff at Purgatory daily.

Q. All right. I want to go back to that phone call with Mr. Johnson.

You said you ordered blood work?

A. I did.

Q. What were you looking for?

A. Any clues as to what was going on. Anything that would help in the evaluation of the plaintiff.

Q. Okay.

A. So I ordered a CBC, which is a complete blood count. And a comprehensive metabolic panel, and that looks at a variety of items. It can give you an idea about whether or not the patient might be acidotic or septic. It can give you an idea about kidney function, liver function, electrolytes, fasting blood sugar. So it's quite valuable in assessment.

Q. Okay. And when you order -- had that ordered, were you looking for anything specific, or were you -- is it just sort of a, "Hey, this is a

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general diagnostic tool that we can use, and if there's clues there, we can follow up on that kind of thing"?

And I don't mean to put words in your mouth, but I think you understand where I'm -- what the generalization of my question is.

A. I do. It was a general evaluation, because of the patient's vague complaints.

Q. Okay.

A. I was hoping to get some clue as to where to go next. Also ordered a chest x-ray. His oxygen saturation was normal, but it was a little less than I expected for a young individual. So we ordered a chest x-ray as well.

Q. Okay. Again, was that just for general diagnosis, or were you looking for something specific?

A. I was looking for perhaps a start of a lower respiratory infection that might explain a lot of the symptoms that he was having. So that was more targeted at the low-normal oxygen saturation. So even though the oxygen saturation was normal, once again, I still expect a young man to be a little bit higher than that. So I thought maybe that would be a clue.

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Q. Okay. Did the chest x-ray reveal anything useful to you?
A. No, it did not.
Q. How about the blood work?
A. The patient refused to have blood drawn. So -- and we can't really draw blood unless we have his cooperation in that regard.
Q. Okay. And how do you know that the patient refused blood draw?
A. I know that he refused the blood draw by the notation in the CorEMR, the charting that was done at the -- at Purgatory.
Q. Do you have that in front of you?
A. I don't know if I can find it.
Q. Well, maybe I can direct you to it. On the bottom of the page, there's some numbers, and if you'll look at No. '501.
A. I don't see '501 or '50-anything.
Q. Well, all right.
Do you have the -- let me show you.
A. Oh, thank you.
Q. I'll show you what's marked as WashingtonCrowson '501.
Do you recognize this as the CorEMR notes?
A. I do.

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Q. Okay. And if we look here on 6-28-14, this is talking about the CBC, CMP.
Is that the blood work that was ordered?
A. It is.
Q. And it says it was attempted --
A. Oh, attempted.
Q. -- without success.
A. Okay. Okay. Then I misspoke. I -- for some reason, I thought that he had declined to have that done. So my mistake on that.
Q. And -- well, and I don't -- I'm asking. Because if this is the evidence we have, then I want to make sure that you don't have any independent recollection, or if you do, that we're getting it out of you.
A. I'll have to look through the notes again, because I thought that I read that he had declined. But perhaps I did not.
Q. Okay.
A. In fact, I don't believe I've seen that particular.
Q. If you want to take -- if you want to take a minute to look through what you've got and find that, that's fine. I want to make sure we're being accurate here.

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A. Thank you.
What's the page number on the bottom?
Q. '501.
A. On the bottom?
Q. Forty-four of 44.
A. Let me see if I have that.
MR. MYLAR: '501 is probably our number.
MR. SCHRIEVER: What's that?
MR. MYLAR: '501 is probably our number.
MR. SCHRIEVER: It is. I didn't know if he had the Bates number or not.
THE WITNESS: I'm not sure where I --
MR. SCHRIEVER:
Q. Let me --
A. -- did see that.
Q. Let me read to you what it says, too.
Down here further, it says, "Patient not willing to hold still at this time."
A. Yes, sir, I see that. So I don't --
Q. Maybe reading that -- I don't know.
A. I don't recollect, then, where I got that, the other information.
Q. Okay. All right. The -- you also indicated that his vitals at that time were not revealing.

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Have you got that page 40 of 44 --
A. I do.
Q. -- in front of you?
A. I do, actually.
Q. Okay. On 6-25-14, do you see that entry?
A. Yes, I do.
Q. Blood pressure at 125 over 78?
A. Uh-huh.
Q. Is that within the normal range?
A. I shouldn't have said "uh-huh." Yes, I do see that. And that blood pressure is actually textbook perfect, yes.
Q. Okay. "P," does that stand for pulse?
A. Yes.
Q. That's 58?
A. Yes.
Q. Is that within the normal range?
A. That's actually a little bit lower than the normal range. Normal range being 60 to 100, but in a young individual, that's not an uncommon finding.
Q. Okay. The "R" at 20, what does that stand for?
A. Respiratory rate.
Q. Twenty, is that within the normal range?

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A. It is.
Q. And then the O2 saturation, 90 at 99 percent?
A. That's normal.
Q. Okay. The glucose at 73?
A. That also is normal.
Q. All right. And then we've got some notes that he's able to verbalize his name, spell last name, unable to remember what kind of work he did prior to being arrested. And then there's a note that says, "Deputies Lyman and Dolgner" -- Dolgner is spelled D-o-l-g-n-e-r -- "say that the patient's affect is different."
Is there any -- anything in there that you are concerned about at that point?
A. Yes, that he's confused, and his affect is different.
Q. Okay. Now, at this time -- this is a note from Michael Johnson indicating that he had seen Mr. Crowson on June 25th.
Do you know if you were contacted at this time?
A. I do not recall that.
Q. Okay. It indicates that he was referred to Jon Worlton.

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Were you involved in the decision to refer him to Jon Worlton at all?
A. I don't believe that I was.
Q. Okay.
A. But I don't recall either.
Q. Okay. Down in the next box, this is still June 25th. It's at 3:23. "Pupils dilated, but reactive to light."
Do you know if Mr. Johnson informed you of that fact?
A. I don't recall being informed of that fact.
Q. Is that something you would be interested in knowing about as the doctor?
A. No. Being reactive light is an appropriate response.
Q. What about the pupils being dilated?
A. If they're fixed and dilated, that's a different story.
Q. Okay.
A. Yes.
Q. But dilated and reactive to light, is that okay?
A. That is okay.
Q. All right. And then I don't have any notes in here from 6-26 or 6-27.
Do you know if you were contacted on either of those days?
A. I don't believe I was contacted.
Q. Okay.
A. If I had been contacted, there should be a note to that effect, and I don't recall being contacted.
Q. All right. 6-28-14, it says, "Patient status: Staffed with MD."
Is that you?
A. That is.
Q. Okay. To the best of your knowledge, is this the day that you were contacted for the first time?
A. To the best of my knowledge, it is.
Q. Okay. And this was a phone call with Mike Johnson; correct?
A. Yes.
Q. Not a FaceTime or a Skype or anything like that?
A. No.
Q. Did you speak with Mr. Crowson at all or just Mr. Johnson?
A. Just Mr. Johnson.

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Q. Is there a day of the week that you go out to the jail?
A. Usually Tuesdays, sometimes Thursdays.
Q. Okay. During the time period, from 6-25-2014 to 7-1-2014, do you know what day you went out to the hosp -- or to the prison, if you did go out to the prison?
A. I don't have a clue. I don't remember when Tuesday would have fallen in that year. And in addition, Tuesdays and Thursdays are my current schedule. I've gone Mondays. I've gone Wednesdays. So I'm not even sure on that.
Q. Okay. No record -- do you have a record of when you went to the jail?
A. I do not.
Q. Do you have a memory of seeing Mr. Crowson at all?
A. I don't recall ever seeing Mr. Crowson, either during this time frame or any other time frame.
Q. Okay.
A. I may have. I just have no recollection of it.
Q. When you do see a patient, do you record it in the CorEMR?

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A. I do. There is a note for each visit that I perform.
Q. Okay. So if you had seen Mr. Crowson, then your name would appear here, in that third column; is that correct?
A. I have no idea on where it would occur.
Q. Okay.
A. So they have an electronic medical record, and I enter in my visits. Where it would appear or not appear, I don't have a clue.
Q. All right. Have you seen anything in the records, that you've reviewed, that would indicate that you did, personally, see Mr. Crowson?
A. I have seen no records of my personal evaluation of Mr. Crowson.
Q. Okay. On 6-28-14, Mr. Johnson noted that, "The BP," I assume that's blood pressure, "is elevated at this time and reported to MD."
A. I'm sorry. What day?
Q. On 6-28-14, at 2:07 P.M.
A. I don't recall that. So...
Q. Okay.
A. It certainly could have happened. I don't recall.
Q. What's -- in terms of what you would have

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been looking for, what would be the significance of elevated blood pressure?
A. Agitation can cause an elevation in blood pressure, certainly. I didn't mean to say "um." Any change in vital signs can be important. But patients, oftentimes, will have an elevation in blood pressure if they're under stress, if they're agitated. So there are any number of things that can contribute to that finding.
Q. Okay. If a patient is exhibiting symptoms of being dazed and confused, not oriented, over a period of three days, is that something that is concerning?
MR. MCGARRY: Objection. Incomplete hypothetical. You may answer.
A. We see a lot of -- a lot of patients that have these very same symptoms. Unfortunately, it is one of the terrible side effects of some of the drug use that we see. You know, many patients can start up normal, and they start using -- you know, the worst drug we see is methamphetamines. And they can develop psychoses. And we see that on a routine basis. So this is not something that is an isolated event.
Q. Okay.

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A. We deal with this quite routinely.
Q. All right. Let's talk about methamphetamine withdrawals.
If a med -- person who's addicted to methamphetamine goes off of the drug, how long does it take for that to get out of their system?
MR. MCGARRY: Object to the form. Go ahead.
A. Usually 72 hours. Sometimes a little longer.
Q. Okay. As far as these symptoms that you called "psychoses" go, is that associated with methamphetamine withdrawals?
MR. MCGARRY: Same objection.
A. A lot of things are connected with withdrawals. People will be confused quite often during the withdrawal stage. They can be agitated. They can have a multitude of symptoms, including hypertension, diaphoresis, tachypnea, tachycardia.
Q. What's diaphoresis?
A. Sweating.
Q. And the second one, the tachy --
A. Tachypnea is rapid respiratory rate, and tachycardia is rapid pulse rate.
Q. Right. How long do those symptoms last in

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a person who's withdrawing from specifically methamphetamine?
A. Fairly short in duration.
Q. Would it be common for them to start two weeks after the person stops using the drug?
A. No. It would be uncommon. Unfortunately, there are times when inmates can have access to some of these products, even despite being incarcerated.
Q. Sure. Have you seen anything in the records that would indicate to you that Mr. Crowson had access to any drugs?
A. That wouldn't be something I would be involved in. I would not have access to any of that information, whether he did or whether he didn't.
Q. Were you aware that he had been in solitary confinement for an extended period of time directly before he was moved to booking for --
MR. MYLAR: Objection. Misstates facts. Those facts are not in the record.
Q. Are you aware of that -- whether that's a fact?
A. I have no idea on that.
Q. Okay. How about heroin? Is -- are the

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withdrawal symptoms from heroin similar to what they are from methamphetamine?
MR. MCGARRY: Object as to form.
A. The withdrawal symptoms to heroin, once again, very nonspecific: Nausea, diaphoresis, tachycardia, tachypnea, elevated blood pressure. And those might last longer than methamphetamine. The half-life for heroin is going to be a little longer.
Q. Okay. And when you say a little bit longer, what's the time period, do you think?
A. I don't know. I couldn't give you a precise opinion on that.
Q. What about alcohol withdrawal symptoms?
A. They can last longer. Usually, the time of onset is within 72 hours of cessation. But especially when you're talking about delirium tremens, that can go on for days and days.
Q. Can it go on for weeks?
A. Not weeks.
Q. Can it start weeks after?
A. No, it cannot.
Q. And by "delirium tremens," what do you mean by that?
A. The DTs, the typical symptoms: Visual

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hallucinations, auditory hallucinations, tactile. I won't call them hallucinations. But you can have odd tactile sensations, confusion, agitation. And then pretty much the same symptoms as we've discussed with the others.
Q. Would not knowing what kind of work you had done prior to incarceration be a delirium tremens?
A. That's a pretty --
MR. MCGARRY: Object to form.
A. -- nonspecific --
MR. MCGARRY: Sorry, Judd.
A. Oh.
MR. MCGARRY: Object to form. Go ahead.
A. Okay. That's a pretty nonspecific complaint. So that could be part of that.
Q. Okay. Do you recall receiving any information from Mike Johnson that's not contained in these notes?
A. I don't.
Q. As you reviewed these notes, did you see anything in there that you thought would be specific, as it relates to a delirium tremens?
A. No, I did not. These symptoms are nonspecific. There are a lot of different disease

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states that these could be present in.
Q. Are they consistent with encephalopathy?
A. They could be.
Q. Now, you reviewed the records from Dixie Regional Medical Center; is that correct?
A. I did.
Q. Did you agree with the diagnosis of toxic metabolic encephalopathy?
MR. MYLAR: Objection. Lack of found -- lack of foundation.
A. Without examining the patient, and just based on my review of the records, I would agree. That's a pretty nonspecific clinical diagnosis, so it would cover a broad range of possibilities. And it would be an appropriate diagnosis from what I reviewed.
Q. Okay. Did -- having reviewed those records from Dixie Regional Medical Center, do you have an opinion as to what Mr. Crowson's condition or diagnosis would have been during the time he was in Purgatory jail?
MR. MYLAR: Objection. Lack of foundation.
MR. MCGARRY: Join. Go ahead.
A. Would you restate that, please?

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Q. I will try. I -- that's a fair -- that's a fair request that I try to restate that.
Given all the information you reviewed, which I believe -- well, let's see here.
All the information you reviewed is the CorEMR notes and the Dixie Regional Medical Center notes; correct?
A. Correct.
Q. You haven't reviewed anything outside of those?
A. I have not.
Q. Okay. So having reviewed those records, do you have an opinion as to what the appropriate diagnosis for Mr. Crowson was, during the time he was in Purgatory jail, from 6-25-2014 to 7-1-2014?
A. Yes, I do.
Q. What's that?
A. Well, fortunately, I have 20/20 hindsight, and I can say it would be metabolic encephalopathy.
Q. Okay. When you are diagnosing a patient with metabolic encephalopathy, what are the symptoms that you're looking for?
A. Confusion is one of the large ones. There also is a physical finding called asterixis, which is very typical if you're dealing with hepatic

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encephalopathy. Specifically, there is a finding of fetor hepaticus. The breath smells fruity, yeah, oftentimes in these individuals. Sometimes there will be jaundice. They can be quite agitated as well. But once again, those fall under many subheadings. But those are the things you might typically see in that case.

Q. Okay. If you suspect that somebody has metabolic encephalopathy, what's the appropriate course of treatment?

A. The appropriate course of treatment in that case, several things. One, you treat the agitation. Number two, you also would give them either neomycin or lactulose. Those help reduce ammonia levels. Typically, you'd give them thiamine, because anyone with hepatic encephalopathy is usually thiamine deficient. They're also usually deficient in other vitamins, so we typically give them a multi-vitamin. We give them thiamine. You would treat them with lactulose or neomycin. You would treat their agitation as well. You know, those are the main things --

Q. Okay.

A. -- that you would use.

Q. What diagnostic tools do you have

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available to you to diagnose metabolic encephalopathy?

A. Once again, the blood work. You can sometimes get a clue. If the acid base balance is out of the norm, that can be reflected in a comprehensive metabolic panel. An arterial blood gas would also tell you some of those items. An ammonia level. Although, an ammonia level needs to be drawn arterially to get the best product. So an arterial draw is something that generally only takes place in the hospital.

Q. Okay. How about an MRI?

A. I would not say that that's useful.

Q. Okay. How soon should a person be treated when they have metabolic encephalopathy?

MR. MCGARRY: Object to form.

A. You would like to treat that person when you first realize that that's what's going on.

Q. Why is that?

A. Quicker recovery.

Q. Okay. Can encephalopathy cause permanent damage?

MR. MCGARRY: Object to the form.

MR. MYLAR: Object. Also --

A. Permanent?

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MR. MYLAR: -- lack of foundation.

Q. Permanent injury to the brain?

MR. MCGARRY: Same objections.

MR. MYLAR: Same objection.

A. On that, I -- I'm not sure I can speak to that. I don't believe so.

Q. If a patient has encephalopathy, it wouldn't be appropriate to wait seven or eight days to treat them, would it?

MR. MCGARRY: Object to form. Foundation. Speculation.

MR. MYLAR: I join on those objections.

MR. MCGARRY: You may answer. Sorry.

THE WITNESS: Okay. Oh.

MR. MCGARRY: You were waiting for me to add some more?

THE WITNESS: Yes, I was.

MR. MCGARRY: Incomplete hypothetical. Sorry. If you want to critique my lawyering, just feel free, Doctor.

THE WITNESS: Am I paying you hourly?

MR. MCGARRY: Apparently, you're not getting your money's worth maybe.

THE WITNESS: Once again, could you restate the question?

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MR. SCHRIEVER: Yeah. Well, in fact, why don't we just have it read back. Then the objections are on the record.

THE WITNESS: All right. Thank you.

(Question read by the reporter.)

THE WITNESS: No. You would want to treat the patient as soon as you realize what the diagnosis is.

MR. SCHRIEVER:

Q. All right. Now, I'll represent to you, Dr. LaRowe, that when I -- when we deposed Ryan Borrowman --

A. Yes.

Q. -- I'll -- I'm paraphrasing, obviously. So we'll just note the objection on the record already.

He didn't have any difficulty identifying Mr. Crowson's symptoms as serious enough to recommend to you that Mr. Crowson be transported?

A. Correct.

Q. Did anything Mr. Johnson ever tell you give you an indication that he -- that Mr. Johnson thought Mr. Crowson's symptoms were significant enough to be transported?

A. No. And our policy -- and I -- the

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nursing staff and myself are all on board with this -- is: You know, the patient comes first. Whatever we need to do to make sure we protect the patient. So no. If Mike had felt that the patient needed to be transported or thought there was even a question, we would have transported him at that time.

Q. Okay.

A. I'm not going to keep someone in the jail when the appropriate course of action is to have them seen in the emergency room.

Q. Which makes your ability to rely on Mr. Johnson critical; isn't that true?

A. It does. It does.

Q. Outside of the -- I know you don't keep notes of -- or records outside the jail.

Do you have any procedures or protocols for following up on patients, who you know have been having some sort of symptoms, like being dazed and confused?

MR. MCGARRY: Let me just ask for a clarification.

MR. SCHRIEVER: Yeah.

MR. MCGARRY: You mean -- so a patient who is still an inmate, when you say "following up,"

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not somebody who's been transferred to the emergency department or been released from the jail, but is sill incarcerated?

MR. SCHRIEVER: Correct, and I can make it more specific.

Q. For example, in this case, Mr. Johnson -- the records indicate that he contacted you on June 28th.

Do you have any kind of tickler system or policies or procedures where on June 29th you would call and say, "Hey, what's going on with Inmate Crowson?"

A. I don't. Mr. Crowson was transported to booking or moved from wherever he was before to the booking area, which is immediately adjacent to medical. And when they are moved to booking, medical will do rounds on them every shift, and I believe the deputies check on them every 30 minutes. And so there's pretty close observation. So that ensures good follow-up. And then if something occurs during their rounds or if they're notified by a deputy, they would give me a call.

Q. Okay. Now, I'm not necessarily familiar with hospital protocol or the way hospitals work.

But you have worked in a hospital; right?

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A. Correct.

Q. When you have patients under your care in a hospital, is there a -- is there a time period in which the doctor is going to say, "All right. I need to check up on this patient," or is there -- how did that work?

MR. MCGARRY: Object to form. Incomplete hypothetical.

MR. MYLAR: Join.

A. In a hospitalized patient, you would round on them daily. That's a minimum.

Q. Okay. And that's the doctor is going to round on them daily?

A. Correct.

Q. And then the nurses are there in addition to that; right?

A. Correct.

Q. In the jail system, that's different?

A. It's not a hospital.

Q. Right. But the purpose of putting him in booking was so that he could be under observation; right?

A. Correct.

Q. And so the nurses are there checking on him once per shift at a minimum?

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A. I believe so, yes.

Q. Okay. But there's no procedure for a doctor or a nurse practitioner or a physician's assistant to round on those inmates daily; correct?

A. No. There is no provision for that.

Q. Okay. Okay. On June 29th, 2014, the note from 7:48 A.M. indicates a heart rate elevated at 140. And again, there's a note here that says, "Staffed patient status with MD."

Do you recall having a second call with Mr. Johnson on June 29th?

A. I did recall, after reading the notes, yes. And then it -- I did re -- recall that, yes.

Q. Okay. And this protocol is Ativan two milligrams IM. What does that mean?

A. Intromuscularly.

Q. Okay. Means give a shot?

A. Yes, it does.

Q. Why Ativan at that point?

A. Ativan has a rapid onset, so I was hoping we'd get a quick response for him. And you know, his symptoms at that time with the agitation, I thought the benzodiazepine would help.

Q. And that's for the liver, the benzodiazepine; correct?

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A. So is Ativan. They're both in the same family.
Q. Are they used to treat alcohol withdrawal symptoms?
A. They are.
Q. Are they used to treat heroin or methamphetamine withdrawal symptoms?
A. They can be, yes.
Q. What was the reason that you prescribed them?
A. It sounded like he was having symptoms that would be consistent with withdrawal, and it's a good drug generally for agitation. For example, oftentimes, we'll also have patients with psychosis, once again, from meth, and benzodiazepine can calm them down quite a bit.
Q. How soon would you expect to see a re -- a positive reaction to the Ativan and the benzodiazepine treatment in a person suffering from alcohol withdrawals?
A. That can be difficult. You know, sometimes with alcohol withdrawal, for a medication like Ativan, I've given it hourly. But I was -- my plan in this case was that the Ativan would help with the initial symptoms and give us time to get

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him started on the Librium and allow that to kick in.
Q. What's the time frame you expect them to have a response to that?
A. That can be difficult, especially with alcohol withdrawal. Some people, it takes a lot of benzodiazepine to achieve a response. And then other cases, they'll have a response quite rapidly. So that is -- there is a huge amount of variability.
Q. Okay. And the patients that have the response rapidly, is that within minutes?
A. No. It would probably be within 30 minutes to an hour --
Q. Okay.
A. -- with a rapid-acting medication like Ativan. Possibly longer with Librium.
Q. Okay. Would you expect to take more than a day to have a response?
A. It can. It can, but I would hope there would be some improvement.
Q. How about two days?
A. You know, once again, in some individuals, it takes a lot. But two days, I would hope to have seen a response.

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Q. Okay. Now, on the 29th, were you aware that Mr. Crowson had been in booking since the 25th?
A. I think the only time I -- I'm not positive when -- of that time frame. I'm not positive that I knew.
Q. Okay.
A. I -- let me restate that. I didn't know at that time how long he had been in booking.
Q. Okay. And we already talked about earlier, but you did not know that he was up in A block --
A. I did not. The first --
Q. -- before that?
A. I thought he was -- when I thought he was in booking was when I received the call from Mike Johnson.
Q. All right. Down there at the note from 6-29-2014 at 3:36 P.M., it's Mr. Johnson's update on his visit with Mr. Crowson at that time.
Were you provided information about that visit?
A. I don't recall. I don't recall on that.
Q. Okay. How about June 30th?
There's no note there. Do you have any

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recollection of being provided information about Mr. Crowson on June 30th?
A. I don't.
Q. And then July 1st, 2014, Ryan Borrowman's note indicates he was sent to the ER for more in-depth evaluation.
Is that something he discussed with you?
A. It is.
Q. You didn't have any objection to doing that; right?
A. Of course not.
Q. And if Mr. Johnson, on June 25th, 2014, would have recommended that, you would have had no objection to that either; correct?
A. They are my eyes and ears.
Q. Are you aware of any standards or criteria for diagnosing alcohol withdrawal symptoms?
A. Yes.
Q. What standards are you aware of?
A. Oh, we look for agitation. Once again, hallucination, verbal and auditory confusion. Usually, you're going to have the tachycardia. So those are kind of the standard things that are looked for.
Q. All right. Anything in these notes or

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anything in your recollection from speaking with Mr. Johnson that Mr. Crowson was agitated or suffering from agitation?
A. Well, I think the confused part, yes. And if you look at the note on the 29th, he actually looked like he was doing better, 9:43 at that time. So yeah, these symptoms are vague and fit a number of diagnostic criteria. But yeah, he -- I would agree with that, the confusion and that.
Q. Okay. And I want to break this down a little bit, because you say you agree. But I'm not sure what we're agreeing with.
A. I'm sorry.
Q. I want to break this down a little bit more.
A. Yes.
Q. When you use the term "agitation" in relation to alcohol withdrawal symptoms, describe that for me. What does that look like?
A. Oh, it can be a variety of findings. Anywhere from being violent and aggressive to not knowing where you're at, what you're doing, not having a recollection of things that have occurred. You know, the classic seeing spiders on the wall sort of thing. Patients can be terribly

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uncooperative during these times. So that's what I would consider to fall under that heading.
Q. Okay. And that's all under the heading of agitation?
A. Yes.
Q. Okay. Like -- and let me -- I'm just asking this. I'm not meaning to argue with you. But like, you said, "Seeing spiders on the wall."
That -- I would consider that a visual hallucination, but does that still fall under the rubric of agitation?
A. I think it's semantics really --
Q. Okay.
A. -- at that point. I mean, agitation is a very broad term.
Q. Okay. And then the hallucinations visually, you gave me the example of spiders climbing on the wall?
A. That's kind of the classic one. Pink elephants or whatever else you want to -- you want to describe. But I've had people think they were ice fishing --
Q. Okay.
A. -- when I would evaluate them. So it can be pretty wild.

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Q. All right. How about auditory hallucinations?
A. Happens too, yes.
Q. Okay. Confusions -- or confusion?
A. Pretty typical with withdrawal symptoms, yes, but once again, not specific.
Q. Okay. And then tachycardia, that's increased heart rate?
A. Anything that causes stress to the system can cause tachycardia, so there are -- there's a huge number of items that fall under that. But being agitated definitely can cause tachycardia.
Q. Okay. All right. I'm going to go through these, and we're -- I want to try to create a checklist of the symptoms that Mr. Crowson was --
A. Yes, sir.
Q. -- exhibiting, to your knowledge. He was confused; correct?
A. Correct.
Q. He wasn't aware of -- he didn't remember things?
MR. MCGARRY: Excuse me just a moment. Ryan, when you say to his knowledge, just so I don't have to make continuing objections, you mean based upon whatever knowledge he has now, after

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reviewing the medical record?
MR. SCHRIEVER: Yeah, and speaking with Mr. Johnson.
MR. MCGARRY: All right. Fair enough.
THE WITNESS: Repeat --
MR. MCGARRY: And speaking with Mr. Borrowman?
MR. SCHRIEVER: Mr. Borrowman as well --
MR. MCGARRY: All right.
MR. SCHRIEVER: -- yes.
MR. MCGARRY: Sorry.
MR. SCHRIEVER:
Q. So he did exhibit some symptoms of confusion; correct?
A. Correct.
Q. Then he was known to be dazed and confused while serving breakfast, and he was unable to remember what kind of work he did prior to being arrested. I'm just scanning through here. He was disoriented, and he gave one-word answers to questions.
Anything else that you see in there that would be a symptom of confusion?
A. Not that I see in there.
Q. Okay. On 6-29, it says he didn't remember

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the last five days.
Would that be -- that would be a symptom of confusion as well; correct?
A. I would agree.
Q. Okay. Anything else?
A. Not that I'm aware of.
Q. Okay. Do you see anything in there that indicates he was violent or aggressive?
A. I did not see anything in there, other than -- the only possible indication was that he wouldn't hold still for the blood draw. But I don't know -- that's not characterized in detail. So I don't know what transpired there.
Q. Okay. On 6-28, it says he was noncompliant with taking deep breaths.
Does that -- is that a symptom that you're -- that's important in any way?
A. Well, it would go along with confusion.
Q. Okay. Any indication of any auditory hallucinations that you're aware of?
A. No, not that I'm aware of.
Q. Okay. How about visual hallucinations?
A. Not that I'm aware of.
Q. How about tachycardia?
A. On the 29th, his pulse rate was up to 140.

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And I -- I'm not positive, when Ryan Borrowman called me, if there were those types of vital signs, tachycardia or any pulse rate issues. I just don't recall. But yeah, the tachycardia on -- let me be specific -- the 6-29-14 at 7:48, that could certainly be related to that.
Q. Okay.
A. I guess he was tachycardic also on the 28th, looking at the records.
Q. Okay. Did the blood work reveal anything to you that was helpful?
A. We didn't get blood work.
Q. Oh, that's right. You didn't, did you?
A. No. No.
Q. That's right. So I guess the answer is no?
A. Correct.
Q. Okay. Did Mr. Johnson provide any indication to you or say anything to you that -- about a source for any suspected alcohol or drugs from Mr. Crowson?
A. No. He didn't. We did speak about that, be -- because it wouldn't be the first time. You know, the inmates have been known to brew their own. I assume it's not the tastiest, but it's --

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you know, it's not impossible to do. So that was part of the differential I was wondering about, whether or not he might have gotten into something.
Q. As far as investigating that, to see if he had gotten into something, is there anything that you could do to determine that?
A. Possibly a drug screen. But it -- you know, either urine or blood possibly would have been useful. It depends at the time of drug use, even with alcohol, obviously. So that might have been useful. So I would leave my answer with that.
Q. Okay.
A. Possibly.
Q. Do you know any specific reason why no blood or urine was tested for drugs or alcohol?
A. I don't have a specific reason why. I didn't order them.
Q. Okay. One of the doctors at Dixie Regional Medical notes -- wondered about the Librium as being a complicating factor with the metabolic encephalopathy.
Do you recall reading about that?
A. I do recall reading it. I took a different interpretation there.
Q. Okay. Tell me what that is.

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A. My interpretation was that because Mr. Crowson had not been on it long enough, he wouldn't have developed a tolerance or an addiction to it. So there was no need to taper off of the medication. And you know, even an alcoholic -- or even in hepatic encephalopathy, I certainly have used Ativan in the hospital setting for these individuals. Ativan, benzodiazepine is in the same family.
And in fact, in review of his previous admission to the hospital, they had used Ativan on him as well. So the Librium might have aided in some of his confusion, just as a potential side effect. But I've used benzodiazepine a lot of times on patients with hepatic encephalopathy. So I don't think it really had any impact on his case.
Q. Does -- the side effect of Ativan, does it increase mental awareness?
A. No, it does not.
Q. Does it decrease confusion?
A. It can decrease agitation, and in the case of alcohol withdrawal, it can decrease confusion.
Q. Okay. Outside of alcohol withdrawal symptoms, what is Ativan used to treat?
A. Agitation, anxiety. Those are the two big

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ones, I would say.
Q. Librium, the same?
A. Yes. Yes. They all fall in the same purview. Some people also use it for insomnia.
Q. How long was Mr. Crowson on Librium?
A. I thought three days, but let me refresh my memory.
Q. Okay.
A. It looks like we started him on the 29th, so three days.
Q. Okay. Anything to indicate that he was given a dose of Librium on the 30th?
A. I believe there's a record on that, but I'd have to refer to the medication distribution.
Q. Let's do that.
A. Do you know what page that would be?
Q. I'll have to look for it as well. Let me find it.
A. Oh, here it is, page 24 of 44.
And what date specifically were you asking?
Q. Well, just -- let's just see if we can -- what does it tell us as far as when he was given Librium?
A. I see that he was given a dose on

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6-29-2014 at 3:39. All right. Actually, I'm a little confused on that. It says, "IM Ativan given in lieu of Librium at that time."
Q. Okay.
A. And I don't know why that would be. Sometimes it depends on what we have in stock, as far as what the pharmacy has delivered. And if it's on a weekend, sometimes, we -- you know, we're not going to be able to get medication. So it is appropriate to substitute one for the other.
Q. All right. And then do you have pages -- let's see. That's 24 of 44.
Do you have pages 25 and 26?
A. Yes, there we are.
Q. What does that show?
A. It shows 6-29 at 6:05 P.M. Librium. 6-30 at 6:34 A.M., received Librium. 6-30 at 10:52 P.M., he refused the Librium. 7-1 at 5:45, received the Librium. And then after that, he was sent -- I believe that's when he was transported.
Q. All right.
MR. SCHRIEVER: Let's go off the record for just a second.
(A break was taken.)
MR. SCHRIEVER: All right. Back on the

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record.
Q. Dr. LaRowe, before we took the break, you had handed me a couple of pages that we didn't have in the book. And I'm not saying I don't have them, period. I just didn't have them in my book here.
But these are pages 25 and 26 of 44 from the CorEMR records. And they show Librium, or at least they purport to show Librium being administered.
Is that your understanding of what they're -- of what they show?
MR. MCGARRY: Well, they show -- I mean, you just mean just the first three lines; right?
MR. SCHRIEVER: Right, on 6-29.
MR. MCGARRY: Or the first four --
MR. SCHRIEVER: -- and then --
MR. MCGARRY: One of them says "refused," but the first four total?
MR. SCHRIEVER: Right.
MR. MCGARRY: Okay.
THE WITNESS: That would be correct.
MR. SCHRIEVER:
Q. Okay. Who is Joshua Billings?
A. He was another nurse out at the Purgatory Correctional Facility.

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Q. Okay. Do these notes provide you any additional insight into Martin Crowson's condition at that time?
A. The -- with the exception of the fact that he refused medication on 6-30 at 10:52 P.M., the other times it shows that he was compliant. As far as why he refused, I could only speculate.
Q. All right. I'll give those back to you.
A. Thank you.
Q. Let me ask you about the role of the nurse in providing healthcare at the jail.
What -- can you describe for me in your words what the role of the nurse is?
A. I will try. The nursing staff will do rounds in respective compartments in the jail, whether it's A block, whatever. Inmates, that are on prescription medications, will come to med pass. So at that point, the nursing staff will interact with the inmates and provide them with medications, or they may decide not to come for their medications or whatever.
And part of the job also is to ensure that the inmate actually takes their medication. For example, sometimes inmates will cheat the medication. They'll store it in their mouth, spit

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it out later, and it can be used as a kind of currency, give it to another inmate or that sort of thing. So they try and ensure that those things don't happen.

In addition, inmates can declare what's called a "medical emergency," where they will ask for a nurse to come and visit them and, you know, evaluate them for specific complaints. Inmates also can contact the nursing staff via the kite system, where you'll send a request. As an example, a patient might have a sore throat or symptoms of a urinary tract infection or those sorts of things. So they can request a medical evaluation there.

The medical staff will also do intake histories when an individual comes into prison. So part of the booking process, I believe, is that the nursing staff will go over a checklist of questions and try and verify any prescriptions the patient states that they're on, try and get an idea of past medical history issues, current medications, current medical status, any complaints. They also will try and review any notes from the ER. Oftentimes, patients are sent to the emergency room for clearance before they are sent to the prison.

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So they get a medical clearance in the ER, and so the nursing staff will oftentimes evaluate that also.

Then we coordinate a list for sick call, you know, for example, on Tuesdays. And they'll review, try and get any pertinent information collected for me when I come in, or if there are things we want to do before I see them in sick call, you know, order blood work, get x-ray testing, get that type of information before I see them. We'll also review any requests for consultative care. For example, an inmate might have come in, who'd had a fracture or something, requiring orthopaedic follow-up, those sorts of things. And the nursing staff also will coordinate care with me by calling me on any specific questions on patients.

There are a number of medications also that are medications that we typically wouldn't think of as medications of abuse, but have been used in that role, particularly in correctional facilities. So we try and sift through the medications that an individual is on, to make sure that we're not providing them with something that might be abused or cause harm or be passed to

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someone else and cause harm, too. So we'll try and scrutinize. Just because they come in for a prescription for drug A doesn't mean we are going to provide drug A, if it might potentially cause harm to them or harm to others if they were to get ahold of it. So...

Q. Okay.

A. It -- that is, you know, to the best of my ability, their role.

Q. Okay. What about diagnosis? Do they play a role in diagnosis?

A. They play a role in diagnosis quite often. I mean, they will give me the symptomatology, the past medical history, and the patient complaints. They're actually quite good with their exams. I mean, they -- it's been a continuous process for them, seeing these patients day in and day out.

So ailments like upper respiratory infections are pretty common for us to deal with, allergy-type symptoms, those sorts of things. So a lot of it is delivering the symptomatology to me. And then at that point, I'll develop a care plan, oftentimes with their insight as well.

Q. Do they ever offer you opinions and say, "Hey, I think this person has X, Y and Z. These

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are his symptoms"?

A. That's hard to say. I think any of us would do that. You know, a mother coming in with her child would say, "Looks like he has a sore throat, you know." And they certainly have the experience. So they might help out in that way, yes.

Q. Okay. In fact, you rely on them to help you out in that way, don't you?

A. Absolutely. We have a great corps there, so we've been working together for, gosh, 15 years.

Q. Okay. Now, Mr. Crowson's symptoms?

A. Yes.

Q. Vague; right?

A. Correct.

Q. You've used that word several times?

A. Yes.

Q. So there are several things it could have been?

A. Yes.

Q. And when you were talking with Mr. Johnson, to a large extent, you were relying on his knowledge and experience to provide you insight as to Mr. Crowson's condition; correct?

A. Correct.

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Q. And then the same with Mr. Borrowman?
A. Correct.
Q. And because of the nature of the situation, you don't have a choice but to rely on them, do you?
A. I don't, no.
Q. When you're looking at the CorEMR records, are you able to see the entries from prior dates?
And I'm talking about at the prison. If you're at the prison, looking on the computer system, can you look at entries from prior dates?
A. I can look at that, yes.
MR. SCHRIEVER: Okay. All right. I don't have any other questions for you, Dr. LaRowe. Thank you.
THE WITNESS: Thank you.
MR. MYLAR: I just have a few. Can I switch with you, so --
MR. SCHRIEVER: Yeah, for sure.
MR. MYLAR: -- it might be easier for the reporter?
(Off the record.)
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EXAMINATION
BY MR. MYLAR:
Q. Hi, Dr. LaRowe. How are you doing?
A. I'm doing well. Thank you.
Q. Just have a couple questions, just to clarify a couple of things.
You were asked by counsel on June 26th and 27th that you did not appear -- it did not appear in the records that you talked to anyone at the jail on those days; is that correct?
A. I believe that is correct.
Q. And if, in fact, the jail is putting him on close watch, the medical area in the booking, and there's -- and he's stable and his vital signs continue to be stable, would there be any reason for a nurse or anyone to call you?
A. I, typically, would not be called.
Q. All right. And I think you had alluded to this, that you've at least heard of or had some experience of inmates getting certain kinds of drugs or home brew while they're in the jail.
Has that been your experience sometimes in the past?
A. Correct.

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Q. And do you have any knowledge or understanding of whether -- or have heard of whether inmates have ever shared their medications with other inmates?
A. It's a common concern.
Q. And --
A. I've had a number of inmates that have transferred their medication to another inmate.
Q. Okay. And do they do those medications in different ways and so on? Are you aware of any that they might --
MR. SCHRIEVER: Objection. Form.
A. I'm sorry?
Q. I agree. The form is terrible.
Do they just ingest it? Do they try to shoot it? Do they snort it? Do you know how -- what kinds of things that the inmates will do with that other medication?
A. Injection is usually not an option.
Q. Right.
A. So I have had inmates that have crushed certain medications and snorted it, and otherwise, it's just ingesting.
Q. Okay. All right. And can that have an effect, a negative effect, on an inmate?

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A. Of course it can.
Q. And can it have even the kind of symptoms that we saw here with Mr. Crowson?
MR. SCHRIEVER: Objection. Form. Foundation. Go ahead.
A. It would depend on the medication, certainly.
Q. Sure.
A. But yes.
Q. All right. And isn't it true that if a -- if an inmate comes into the jail and they've been in before, because of different drug use or different things like that, and they've had a history of at least a few years of using illegal drugs, do those present a little bit more difficult presentation to you, as a physician, in terms of trying to deal with and treat an inmate like that?
A. It would, because there are so many variables involved, especially if you're talking about an individual that has experimented with a number of different medications or drugs in the past.
Q. Uh-huh. Okay. All right. And would they be more at risk for some unusual thing happening potentially? Can that -- or can that -- can

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something unusual happen, in terms of their health, because of their long-term use of illegal drugs?
A. If they've had long-term use of medications, there are several things that can happen. Most of us have a fair amount of tolerance to a variety of circumstances, whether --
Q. Uh-huh.
A. -- it's taking a drug or other insults, having a fever or those sorts of things. But some people have less -- I'm searching for the right word -- less leeway. For example, a patient, who has borderline dementia, takes a medication. And their dementia will be unmasked --
Q. Uh-huh.
A. -- because they just don't have the leeway --
Q. Uh-huh.
A. -- that one of us would have. So if there -- if someone has had previous insults, you might then unmask other problems, that you might not otherwise see for years down the road.
Q. Okay. In this case, there seem to be at least some thought of the jail staff that they thought that he was withdrawing. When you -- looking back as to what you only knew then, not

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what you know now, were those reasonable thoughts and information that they might think he's withdrawing, based upon the records?
A. It could have been. You know, that was certainly one of the top options in the differential.
Q. Okay. All right. And if someone just starts to exhibit some symptoms of withdrawal in a jail, that's not the time necessarily to send them right off to the hospital, is it?
A. We deal with withdrawal all the time in the prison setting. And in fact, the emergency room will send these patients to us, you know, when it -- when their symptoms become such -- I'll use alcohol withdrawal as a specific one. Because it's the one we see most commonly, and it's easy to state clearly. But when their symptoms become such that you think they're on the verge of DTs or even if they go into delirium tremens, that can be a life-threatening event. And that's when we send them back.
Otherwise, we deal with a lot of their symptoms at the time with what we have available. And usually, it's a Librium taper. They will have the tachycardia, the nausea, the diaphoresis.

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They'll go through those symptoms. But as long as they don't exhibit seizure activity, delirium tremens, those clear-cut things, we're going to manage them in the facility and do it all the time. The hospital wants nothing do with this.
Q. Okay.
A. So...
Q. And someone can be in withdrawals and not show any DTs; is that correct, too?
A. Oh, correct. DTs are at the end of the spectrum --
Q. Uh-huh.
A. -- of withdrawing. That definitely can be life threatening.
Q. Well, when an inmate goes to the hospital -- let's say before they're an inmate. When they're just being arrested and they go straight to the hospital and they're released to the jail, is that really any different than a hospital releasing them just to go home?
MR. MCGARRY: Object to form.
MR. SCHRIEVER: Join.
A. It is different. In this case, there are times when the hospital might actually keep the patient, if they were going to go home --

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Q. Uh-huh.
A. -- or send them to a rehabilitation facility or something like that.
Q. Uh-huh.
A. But they will send them to us. So our -- they're going to expect more care out of us.
Q. Uh-huh. Okay. All right. But they don't say that in their release at all, do they?
A. They do not.
Q. They just say that he's released from the hospital?
A. Correct.
Q. All right. And do you know if Mr. Crowson went to the hospital in this case?
A. I don't know that.
Q. Okay. And based upon the information that you had in this case, you did not see any reason to transfer Mr. Crowson to the hospital, until you got the information on July 1st; is that correct?
A. Correct.
MR. MYLAR: All right. I don't have any further questions.
MR. MCGARRY: Any questions?
MR. GRAF: No.
MR. MCGARRY: No questions here.

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MR. SCHRIEVER: A couple follow-up questions.
THE WITNESS: Yes, sir.
-oOo-
EXAMINATION
BY MR. SCHRIEVER:
Q. Mr. Mylar asked you about the options for differential diagnosis, and let's break this down a little bit.
Differential diagnosis means what?
A. Well, let's call it your "usual suspect." What are your -- what are the most likely conditions that would go along with these symptoms?
Q. Okay. And in this case, the usual suspects, you said one of the top was withdrawal?
A. Yes.
Q. Okay. Context is important there, though, isn't it?
A. It is.
Q. Because outside the prison, withdrawal isn't one of the top suspects, is it?
A. No, it's not.
Q. In fact, when he went to the hospital and was treated at the hospital, they didn't consider withdrawal, did they?

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MR. MYLAR: Objection. Lack of foundation.
Q. Based on your review of the records?
MR. MCGARRY: Join.
A. I don't know that. I don't know that. They had the advantage in reviewing the record of having laboratory studies to review, too.
Q. Right.
A. So...
For example, they had ammonia studies that they could do arterially there; correct?
A. Yes. Absolutely.
Q. So -- and if a person comes in off the street in the hospital -- and you've had experience in a hospital, so this is -- I think is a fair question -- not knowing what they do for work, not responding to -- with multiple words to questions, appearing dazed and confused, you're going to start looking at insults to the brain in some way as the top suspect, wouldn't you?
A. I would actually still look at drug use.
Q. Okay. And what would you do to look at the drug use?
A. Well, I would do a tox screen. I'd review previous records, you know. If the individual's

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been seen at the facility before, you could gather a lot of data from that. Breathalyzer possibly could be used, too, in that case. There are certain -- you can't test for huffing, so there's no blood tests for those sorts of things. So yeah, you could eliminate certain groups with the correct testing.
Q. And if you were working at the hospital, that would be the standard of care; correct?
A. Working in the hospital emergency room setting, I would expect it would be.
Q. Okay. And is there a different standard of care in a jail?
A. It's not a hospital. It's not an emergency room.
Q. Okay.
A. So I would expect there would be a difference.
Q. So no tox screens at the jail?
A. You know, I can't recall that I've done one. It would have to be sent out, because there is no lab at the facility itself.
Q. You'd agree with me, in the hospital setting, that tox screen is important, because when you're dealing with a differential diagnosis, it's

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useful to eliminate --
A. It is.
Q. -- certain causes, potential causes?
A. I would agree with you.
Q. Okay. That was not done in Mr. Crowson's case at the jail, though; right?
A. No.
Q. Okay. And you'd agree, wouldn't you, that one of the reasons that drugs and alcohol was a suspected cause was because he was in prison or in jail?
A. That is a population we take care of.
Q. In your interactions with Mr. Johnson, was it your impression that Mr. Johnson thought the top suspect was drug or alcohol withdrawal?
A. It was a consideration, but it was -- there was always a question of what else might be going on with him. And that's one of the reasons we moved him to the booking, was to keep an eye. Because it was not clear-cut. You know, the other things that we had to look at.
You know, at some point, psychosis has to start somewhere. You know, you have to have that initial event. So you always wonder about someone that might have had previous drug use, because we

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see so much psychiatric ailments, as a result of that. They have to -- they have to start somewhere. So that was certainly one issue that we thought about.

Infection also is something that you worry about with confusion. So I would have dearly loved to have had the CBC to look at that. We did check the chest x-ray. No signs or symptoms of a urinary tract infection. So you know, there were a number of things we were looking at. It was not clear-cut.

Q. Okay. What indications did you see there wasn't any sign of a urinary tract infection?

A. Well, typically, in a male, they're pretty aware of that. You know, that's why STDs are detected more easily in men. And women can have an STD that they're not aware of at all for awhile. And I have seen a number of female patients with urinary tract infections that have gone to the point of sepsis before it's ever recognized.

Q. So let's go -- let's just do this real quickly.

When you're dealing with differential diagnosis, the first step, rather than determining what the cause of the symptoms is, is to eliminate

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other causes; right?

So you've got a checklist, and your checklist was alcohol withdrawals, infections, urinary tract infections, respiratory issues.

What else am I -- what else am I missing?

A. Possibly psychosis.

Q. Okay. Did encephalopathy ever make it onto the radar?

A. It did not. It did not.

Q. Okay. That's in large part because it didn't get onto Mr. Johnson's radar to be conveyed to you; right?

A. Well, also, we didn't have -- I didn't have at my disposal the previous admissions. And in fact, from reviewing the chart, I think this was the first time he had been diagnosed with hepatic encephalopathy. I'd -- you know, he'd come in with a mult -- on review of previous hospitalizations, he'd come in with a number of other things, you know, and actually been in the ICU and whatnot. But maybe I missed it, but I didn't see hepatic encephalopathy noted before.

Q. Mr. Johnson didn't give you any indication he thought Mr. Crowson should be transferred to the ER, did he?

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A. No. If there's an -- if there's a thought that we need to transfer them, we always err on the side of transporting.

Q. And Mr. Borrowman did?

A. He did.

Q. Have you spoken with either of them, or do you have any knowledge as to why they viewed this situation so differently?

A. I have not. On review of the records, even in Ryan Borrowman's case, I didn't see the vital signs there. I -- it was more of a gestalt on his part, I think, that the patient was doing poorly. There may have been vital signs recorded; I just didn't see them. But if he's going to tell me the patient needs to go, I'm sending him.

Q. Do you know what the results of the chest x-ray were?

A. They were negative, I believe, in that there was no pathologic process noted.

Q. No signs of infection either; right?

A. No, there was not.

Q. Okay. You talked about -- with Mr. Mylar's questions, you talked about seizures, seizure activity, being a sign of withdrawal; is that correct?

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A. It can be, yes.

Q. No indication of seizure activity with Mr. Crowson; right?

A. There was none noted.

Q. Okay. What is the jail policy as to when a patient should be transported to an emergency room?

A. I'm not aware of any set policy. There may be. I'm not aware of one. It, usually, is based on a discussion between the nursing staff and myself.

Q. Okay.

A. Our unwritten policy, you know, is protect the patient, protect our license.

Q. What role did Mr. Crowson's prior drug use play in his encephalopathy?

MR. MCGARRY: Object to form.

A. It could have played a huge role in his hepatic encephalopathy. You're not going to develop hepatic encephalopathy de novo. You have to have injured your liver to the point where it's in a tenuous situation, where one more insult can tip you over the edge where your body is not able -- where your liver is not able to eliminate the ammonia, which is typically what we see go.

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And that can happen in various circumstances. For example, IV drug users, you know, you always have to consider the possibility of hepatitis C or hepatitis B. Genetic things like sclerosing cholangitis, injury to the liver based on alcoholic consumption or alcoholic cirrhosis, nonalcoholic steatohepatitis or NASH syndrome. So usually, there has to be an injury, either infectious, toxic, like alcohol, or genetic. Those are the typical ones that we'll see.

Q. All right. Hepatitis C, potential contributing factor?

A. Of course, yes.

Q. Are you aware that Mr. Crowson was diagnosed with hepatitis C?

A. I was not, and on his intake form, he -- on review, in my 20/20 hindsight, he -- I believe he did not note that to the staff.

Q. Any indication from Mr. Johnson that he was aware that he had hepatitis C?

A. I don't recall that.

Q. Any indication from Mr. Johnson's notes or from your conversation with him that there was the possibility of a prior insult to the liver that could lead to hepatic encephalopathy?

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A. Not that I recall.

Q. If a tox screen had been done and drugs and alcohol were eliminated as causes of this, what would your next step have been?

MR. MCGARRY: Objection. Object to form. Calls for speculation.

MR. MYLAR: Join.

THE WITNESS: I probably would have done the same thing. I would have watched, you know, as long as the vital signs were stable. Because we do see confusion and agitation very commonly out there. So I think the next step -- now, this is purely speculative, you know, and so I can only speak to what we've done in the past. I would have continued observation, continued gathering vital signs and trying to get more information. Might have had him evaluated by mental health people out there, might have considered, "Gosh, is this an individual where we should look at using one of the psychotropic drugs? You know, is this the beginning of his psychosis or schizophrenic-like ailment?" I don't know.

MR. SCHRIEVER:

Q. How many days is it reasonable to keep a person in a dazed, confused state without investigating those other potential causes?

MR. MCGARRY: Object to form. Incomplete hypothetical.

MR. MYLAR: And also calls for speculation. I join in those.

A. That one -- that one's hard to say. I think it depends on findings while you're observing them. If they're safe, in that they're taking nourishment, they're drinking water, they're not harming themselves, I think those all play a role. If they're stable, in that their situation is not deteriorating, I think it's fine to continue to watch and gather information.

Q. Okay. Let me give you a -- I'll represent to you what a note says, and you can use this. And then I'll give you a question after.

A. Okay.

Q. My representation is that one of the notes says that a deputy gave Mr. Crowson his clothes and told him to get dressed. Mr. Crowson put his underwear on his head.

A. Okay.

Q. Is that something that would be -- that you would look at to determine whether or not there's a serious issue happening?

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MR. MCGARRY: Object to form.

MR. MYLAR: Objection. Also calls for speculation. Also lack of foundation.

A. That's not an unusual occurrence. We deal with a lot of psychological illness there. In today's day and age, the prison systems house the mentally ill. They can't help but commit a crime when they're on the outside. So we see that type of thing a fair amount.

Q. Okay. And if a nurse asked him to take deep breaths and he was unable to follow that simple of an instruction, is that a serious symptom?

MR. MCGARRY: Same objections.

MR. MYLAR: Join.

A. Once again, it is related to his degree of confusion. We've had people weaponize excrement in the prison. So I -- if you're going to throw a bomb, an excrement bomb, you know, that's fairly serious. But we don't send them to the hospital for that.

Q. Okay. But my question was: Inability to follow simple instructions, such as take a deep breath?

A. These people don't follow those

instructions either. We see that all the time. It's not uncommon.

Q. In a hospital setting, those would be viewed differently, though; correct?

A. They would be. They would be. It's a tough situation, because we have individuals that are noncompliant. Oftentimes, there is the issue of secondary gain through their actions, and it makes the whole medical evaluation process that much more difficult.

MR. SCHRIEVER: All right. Thank you, Dr. LaRowe. I don't have anything else.

MR. MYLAR: I don't have any questions.

MR. MCGARRY: We'd like the opportunity to review and sign. If you'll send it to me, I'll get it to Dr. LaRowe.

MR. MYLAR: And I would like a electronic version, as well as a minuscript.

MR. MCGARRY: Send me everything. Just anything you can bill for to make up for those thousand burpies you missed today.

(The deposition concluded at 11:00 A.M.)

CERTIFICATE OF DEPONENT

PAGE	LINE	CHANGE	REASON

*****

I, DR. JUDD LAROWE, deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcription to be my deposition in said action; that I have read, corrected and do hereby affix my signature to said deposition.

_____

Deponent

Subscribed and sworn to before me this _____ day of _____, 2018.

_____

Notary Public

REPORTER'S CERTIFICATE

STATE OF UTAH)
) ss
COUNTY OF WASHINGTON)

I, J. ELIZABETH ROBISON, Registered Professional Reporter, Washington County, State of Utah, do hereby certify:

That I reported the taking of the deposition of the witness, DR. JUDD LAROWE, commencing on Wednesday, June 6, 2018, at the hour of 9:03 A.M.

That prior to being examined, the witness was by me duly sworn to testify to the truth, the whole truth, and nothing but the truth.

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true and accurate transcription of my said shorthand notes taken at said time.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand in my office in the County of Washington, State of Utah, this _____ day of _____ 2018.

J. Elizabeth Van Fleet

_____

J. Elizabeth Robison, RPR, CCR